Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005099	A. BUILDING _____ B. WING _____	12/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBUS REGIONAL HOSPITAL	2400 E 17TH ST COLUMBUS, IN 47201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of one (1) State complaint. Date of survey: 12-03-12 Facility number: 005099 Complaint number: IN00116221 Unsubstantiated: Lack of sufficient evidence. Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor Columbus Regional Hospital is in compliance with 410 IAC 15-1.5-6, Nursing services and 410 IAC 15-1.6-7, Respiratory therapy, Hospital Licensure Rules. QA: claughlin 12/14/12	S 000		